

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 0 - 0 0 8

2. STATE:

New Mexico

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

September 1, 2000

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.167

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 \$ -0-

b. FFY 2001 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

~~Attachment 3.1-A, Page 9~~

Attachment 3.1-A, Page 10 \*

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):~~Attachment 3.1-A, Page 9~~~~Supersedes 09-05~~

None, New Page

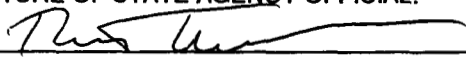
10. SUBJECT OF AMENDMENT:

Extends Personal Care Services to outside the recipient's home

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Robert T. Maruca

14. TITLE:

Director

15. DATE SUBMITTED:

September 1, 2000

16. RETURN TO:

Robert T. Maruca  
Medical Assistance Division  
P.O. Box 2348  
Santa Fe, New Mexico 87504**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

October 31, 2000

18. DATE APPROVED:

November 1, 2000

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

September 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Calvin G. Cline

22. TITLE: Associate Regional Administrator  
Division of Medicaid and State Operations

23. REMARKS:

\*11-03-00 - Per State's Request, Attachment 3.1-A, Page 10, replaces Page 9.

State: \_\_\_\_\_

\_\_\_\_\_  
AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

\_\_\_\_\_ provided \_\_\_\_\_ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

  X   Provided:   X   State Approved (Not Physician) Service Plan Allowed  
  X   Services Outside the Home Also Allowed  
\_\_\_\_\_ Limitations Described on Attachment  
\_\_\_\_\_ Not Provided.

STATE <u>New Mexico</u>	A
DATE REC'D <u>10-31-00</u>	
DATE APPV'D <u>11-01-00</u>	
DATE EFF <u>09-01-00</u>	
HCFA 179 <u>10-08</u>	

TN No. 00-08  
Supersedes \_\_\_\_\_ Approval Date 11-01-00 Effective Date 09-01-00  
TN No. \_\_\_\_\_  
SUPERSEDES: NONE - NEW PAGE